

**State Employee Benefits Committee
Tatnall Building, Room 112
Dover, Delaware 19904**

The State Employee Benefits Committee met August 21, 2017. The following people were in attendance:

Committee Members:

Mike Jackson, Director, OMB, Chair
Bethany Hall-Long, Lt. Governor
Sandy Johnson, Secretary DHR
Molly Magarik, Designee of DHSS
Evelyn Nestlerode, Designee of Chief Justice, Administrator of Courts
Ken Simpler, State Treasurer
Trinidad Navarro, Insurance Commissioner
Jeff Taschner, DSEA
Victoria Windle, Designee of CGO

Guests:

Brenda Lakeman, Director, Statewide Benefits Office (SBO)
Faith Rentz, Deputy Director, SBO
Lisa Porter, SBO
Patricia Davis, Designee of DOJ
Rebecca Byrd, The Byrd Group
David Craik, Pension Office
Jacqueline Faulcon, DSRPA
Leighann Hinkle, SBO
David Leiter, DHSS
Lucinda Lombardelli, PHRST
Melissa Marlin, OMB
Regina Mitchell, OMB
Evan Park, Univ of DE
Karol Powers-Case, DRSPA
Leslie Ramsey, SBO

Guests (continued):

Nathan Roby, OST
Paula Roy, DCSN
Jeff Savin, OMB
Aaron Schrader, SBO
George Schreppler, DCSN
Stuart Snyder, DOI
Jim Testerman, DSEA-R

Katherine Impellizzeri, Aetna
Mike North, Aetna
Jackie Ball, Aetna
Heather McKenna, Aetna
Shari Sack, Aflac
Carrie Schiavo, Delta Dental
Wendy Beck, Highmark
Drew Brancati, Highmark
Peg Eitl, Highmark
Jennifer Mossman, Highmark
Kevin O'Hara, Highmark
Pam Price, Highmark
Jerry Walsh, Highmark
Judy Grant, HMS
Walt Mateja, Truven Consulting
Kevin Fyock, Willis Towers Watson
Jaclyn Iglesias, Willis Towers Watson
Rebecca Warnken, Willis Towers Watson

Introductions/Sign In

Director Jackson called the meeting to order at 2:02 p.m. Introductions were made.

Approval of Minutes - handout

The Director entertained a motion to approve the minutes from the July 24th SEBC meeting. Ms. Magarik made the motion and the Lt. Governor seconded the motion. The motion carried.

Director's Report – Brenda Lakeman, Statewide Benefits Office (SBO)

- A final breakdown of Open Enrollment (OE) by agency and schools was provided showing total count of benefit eligible employees in each area, total count of participation in ebenefits online and percentages.
- Follow up on the On-Site Clinic information from the last meeting was provided with input from the consultants, Willis Towers Watson (WTW) and Deputy Attorney General (DAG) with plans to address further at the October or November meeting to determine next steps.
- SBO conducted a post OE survey sent to the benefit representatives throughout the State that produced a 36% response rate with good suggestions and feedback to utilize in the next Open Enrollment.
- Double State Share (DSS) FAQ's have been posted to the SBO website with rate table effective January 1, 2018.

Financial Reporting

Revised June 2017 Fund & Equity (F&E) Report - handout – Faith Rentz, SBO

The revised June statement shows highlighted sections where adjustments were made compared to the original statement presented in July. Adjustments are seen in the Year-to-Date Actual and Variance columns, primarily attributed to changes made in some of the formula adjustments in accounting to the January through June reporting which had an impact in the YTD column. Specific to June, changes were made to the Medicare Retiree RX Direct Subsidy line item under Other Revenues. The original June statement indicated a \$1M deposit that actually included the Direct Subsidy, Federal Reinsurance and Low Income Subsidy Funds. This was broken out in the revised June statement with a change of \$267 and ending balance of \$102.7M. In the YTD Actual column under Prescription Drug Rebates-Commercial, the original June statement reported a \$14.7M YTD balance where this item now reflects a \$28.4M balance due to an adjustment to move a commercial rebate payment up into this item to align with the actual budgeted amount.

Updated FY18 Budget - handout – Rebecca Warnken, WTW

The impact on the FY18 budget as prepared is marginal as the year-end balance changed only by \$300. WTW updated the FY18 budget to reflect the latest projections and some different EGWP payments. CMS released the Direct Subsidy payments for Part D for CY18 and those amounts are lower than the current subsidy levels, so WTW made an adjustment and reduced overall budget by \$0.4M to reflect the fact that the State will be collecting less in direct subsidy payments in the 2H-FY18. At the September meeting, WTW plans to share the full FY17 Q4 Financial Reporting package.

FY18 Planning – handout - Presentations by Aetna & Highmark on Value Based Contracting and Centers of Excellence

Aetna: Jackie Ball spoke on Value Based Contracting (VBC) with Aetna's goal of 75% of payments expected to be value-based by 2020. Aetna currently has 53.7% penetration or spend in VBC. Information on Aetna's multi-year plan to convert entire network to value-based payment, value-based care models, and 46% of providers and 44% of membership in VBC arrangements was shared. AIM HMO designed exclusively for State of Delaware GHIP went live on July 1, 2017 and should accelerate Aetna's VBC footprint. Katherine Impellizzeri shared Aetna's view of Center of Excellence with Aetna's Institutes Program: Institutes of Excellence™ focuses on transplants where Institutes of Quality® focuses on three surgery categories for orthopedic, cardiac and bariatric.

Highmark: Peg Eitl provided an overview of Highmark in Delaware. Jerry Walsh, Highmark VP of Provider Contract Relations provided highlights of how Highmark is transforming health care delivery. Reimbursements to be in alignment with the payor and the provider to move in the same direction. DRG refers to inpatient and all hospitals are contracted in a DRG reimbursement methodology in Delaware. APCs refers to outpatient with a similar model to get providers engaged in taking some of the risk and is patterned off of Medicare. Hospitals are in various stages of adoption of APCs. The call out "We Are Here" shows where Highmark is within their combined markets. Delaware today lags behind Highmark's other markets in transitioning from Pay for Performance over to Value Based / Global Payments. An overview of Highmark's True Performance Program (TPP), a value based program existing in Delaware today was provided. Highmark's assessment of the progress in moving our hospital organizations from pay for performance to value based shows that Delaware hospitals are lagging behind in their readiness and willingness to accept risk compared to other markets. Infrastructure (personnel, commitment, technology, software) needs to be put in place before they can manage it. Hospitals in Delaware, like the rest of the country, are buying up physician practices which will drive up the unit cost. Value based care is already engaged by Medicare and driving it toward the hospitals. Highmark has about 1.5M lives under their TPP and in Delaware about half of physicians are under TPP, representing about 80% of spend. Highmark will provide more understanding of the Global Care model in the reimbursement market in percentage wise with Delaware compared to Highmark's entire footprint. Lt. Governor stated we are moving in the right direction and in the near future hope to have some serious discussion about the preventative measures and how we lower those costs and expand to those providers. Ms. Magarik inquired as to providers that are not yet in TPP. Highmark stated these providers may have not been approached by Highmark yet for reasons of low volume or lack of readiness due to the need to get the infrastructure and staff in place. Waive two is in progress for enrollment for 2018. The Treasurer inquired of WTW as to how Aetna and Highmark can choose their own metrics for Centers of Excellence or Centers of Distinction as these are not defined by a national ratings board. Mr. Fyock noted, that both carriers utilize their own methodologies determine quality metrics, in either Centers of Excellence or Distinction. Most often, the carriers are

utilizing and accreditation process by appropriate external entities, such as NCQA or the Joint Commission for Health Care.

FY18 Planning and Plan Management – handout – Willis Towers Watson Team

Long Term Health Care Cost Projections for GHIP was presented by Rebecca Warnken with updated claims experience through June 2017 and reflecting the initiatives adopted July 2017, including vendor value-based care models (Aetna- AIM and Highmark True Performance), enhanced Highmark clinical management program (CCMU) and utilization management through U.S. Imaging. The projected GHIP deficit has been reduced by \$133M over 5 years compared to prior estimates. This does not contemplate earlier discussion any of the savings that were generated in FY17 so that is surplus above the claims liability and reserve. We are not showing any additional surplus generated into FY18 in this exhibit. If claims experience comes in as expected, 2018 may be lower.

Fiscal year 2019 has been updated based on claims data through June 2017 and reflecting savings from several value based care models as Aetna AIM and Highmark TPP implemented July 1st along with Highmark's new clinical model CMU and utilization management through U.S. Imaging. Prior projection of a \$47M deficit in 2019, has been reduced to \$40M along with reducing the projected trend from 6% to 5% as a result of these changes. Improved quality and health of the population of Delaware are expected which will continue to reduce the trend and generate longer term savings. With comments from the Treasurer and Director, WTW will update the Long term health care projection chart adding a second bar to model what a premium change would look like.

FY18 Planning continued by Kevin Fyock showing focal points for SEBC on potential changes for the second half of FY18 to achieve the targeted \$2M savings. Voting would occur at the September meeting. Short term opportunities include Site-of-Care Steerage, Centers of Excellence, and Reference Based Pricing along with an additional savings opportunity in ESI's EGWP maintenance network.

Dialogue occurred with concern of cost shifting to employees, minimal employee engagement and interest in exploring opportunities for overall reduction of the GHIP spend. Additionally comments were made regarding a commitment to complete the benchmarking of hospitals against other organizations and a review of employee total compensation as outlined two years ago in the Health Fund Task Force and need to update the timeline blueprint for tackling SEBC savings charge from the \$2M targeted savings on a \$800M Fund to get to the larger savings target. Also noted some of these changes to drive down overall cost will require legislative action as that is beyond the scope of this committee.

Site-of-Care Steerage presented by Jaclyn Iglesias provided a refresher of this opportunity where members pay lower out-of-pocket costs for using the most appropriate place of service for the care they need. This is already in place in the GHIP with the high-tech imaging services and urgent care. Opportunity exists to expand in other key service areas such as basic imaging (x-rays, ultrasounds) and outpatient lab services. Both Aetna and Highmark have demonstrated this can change member's behavior towards using low cost facilities with no impact to quality of care. WTW to confirm when a hospital owns a free-standing facility, is this free-standing facility considered hospital based with member paying a higher rate. The current understanding if billed by the hospital, the charge is at a hospital rate. SBO already has a list of free-standing facilities on the website for members. SBO will present through FY17Q3 an analysis of how these changes have impacted behavior and generated savings. An estimated FY18 savings for the Site-of-Care Steerage is \$0.5M. WTW to bring options in estimated savings to the GHIP plan if copays were adjusted for these services.

Center of Excellence (COE) is another refresher topic where Aetna and Highmark designate certain facilities within their networks as COEs. Today, the GHIP utilizes the COE network for bariatric surgery and transplants. Dialogue around the hospital providers, procedures and provider outside of the network occurred. Mr. Fyock added that Highmark is rolling out a tool that can steer to other facilities that may not be listed for GHIP as COE but designated COE through another carrier and will provide more information and if it is quality and also cost effective. An expansion of COE specific services is proposed for cardiac, orthopedic and spine. COE facilities are available within a 100 mile radius of Delaware but may not be in Delaware. The travel and lodging benefit in place today for the transplant and bariatric surgeries would follow suit for these procedures. Standards set by the carriers designate their COEs facilities where these may be addressed by volume, quality differentials or metrics with more details to be provided. An estimated savings for second

half of FY18 is \$0.4M for Aetna's COE and \$1.2M within Highmark's COE for a total savings of \$1.6M. Roughly \$0.9M of the \$1.6M savings FY18 attributable to plan design cost shifting assuming that a portion of the members use non-COE facilities despite the higher cost sharing. Remaining savings of \$0.7M related to improved quality standards of COE-designation.

Reference-based pricing (RBP) is another refresher topic. Vendors have the capability to take advantage of this program. WTW has zero clients that has RPB in place today. Certain savings can be achieved but it does come at potential member cost. RBP is where the plan sponsors agree to pay a fixed amount for a service. Members that seek care above that reference have a potential to be balance billed and those that seek less than the reference price, will not have to pay anything additional. RBP works best with coinsurance programs versus copay programs. RBP differs slightly between Aetna and Highmark in terms of covered procedures and network breadth. With limited data Aetna and Highmark cannot conclude whether or not changes in member utilization patterns have occurred as a result of RBP. For RBP to be successful, intensive communication would need to be rolled out with member education. Estimated FY18 Savings is \$0.9M.

Voting on these three savings opportunities for implementation January 1, 2018 to be taken at the next meeting.

Director Jackson commented on the options with COE related to the lack of facilities available within the State and that RBP would have more impact on members with a number of challenges. With the Fund and Equity balance ending the year at \$24.7M and expecting to grow to \$36M, there is an option to utilize some portion of funds forecasted in the budget and allow the longer term conversation to occur for FY19. Treasurer added if some or all of these changes were implemented for the second half of FY18 and carried over into FY19, without any premium increase, this may solve the financial concern.

Ms. Magarik added that House Joint Resolution 7 directed Secretary Walker to look at the All Payor Model along with a benchmark which would set a health care funding target and a growth rate target to some alignment of the economy whether revenue growth or to be determined. Many of these changes are incremental, the intent of establishing a particular benchmark (3 or 4%) is to slow the growth curve.

Mr. Taschner asked the providers to put forth an aggregate at the next meeting of the savings for COE in cardiac, orthopedic and spine. Director added COE would create an impact in such a short period of time, plus getting information out to employees would be difficult and suggest to move it longer term in FY19. Mr. Taschner also inquired if possible to look back two to three years on how many procedures the plan paid for that would fall into the COE areas.

EGWP 90 day Maintenance Network – handout - Brenda Lakeman

Express Scripts (ESI) is putting this change in place for its employers with Employer Group Waiver Plans, the Medicare Part D prescription plan, for all of its clients. This is not an option for CY18 but we have the option of when this is implemented during CY18. The implementation date would impact savings. The question as to whether the Federal guidelines indicating the narrow network is in compliance with state Any Willing Provider statutes is in fact compliant in Delaware is being vetted by Delaware's Department of Justice. Not all of the pharmacies currently in the 90 day maintenance network would be in that 90 day maintenance network for the Medicare population, specifically it would be Walgreens, independent pharmacies and ESI mail order. There would be some disruption with 8,771 members out of the 23,000 Medicare members but the distance to drive to another network pharmacy is under three miles. For the entire CY2018 the estimated savings is \$490K. Ms. Lakeman asked the committee to review the handout before the next meeting and direct questions to her attention. SBO suggests to put in place March 1st as long as the vetting is completed by the DAG. Ms. Rentz added for the Active & Non-Medicare retirees, they are required to fill a maintenance medication at 90 days to avoid being penalized. This is not the case with the EGWP plan and will continue as is.

Disability Rule and Regulation Proposed Changes – handout - Brenda Lakeman

This was a revisit of the Disability Insurance Program Rules change that was brought to the committee at the last meeting. The change to the language, background and process for this change shown in the handout. This rule will allow the State of Delaware the opportunity to collect from the member's Long Term Disability (LTD) payment to repay

the State for any overpayments on the Short Term Disability (STD) side. Concerns expressed at the last meeting were addressed. A large majority of these claims are because of a large retroactive Workers' Compensation award or SSDI retroactive payments or some instances where an individual was being paid and had already returned to work. In FY17 there were potential overpayments of \$417K in STD. We need to be sure the Pension disability fund that funds the STD payments recoups this money.

Public Comments

Mr. David Leiter, DHSS shared his concern when making medical decisions that the SEBC needs to think about the person who is in pain and having to go through all kinds of processes to get services when the member goes to where their doctor says go to this place.. Concerned Aetna had no COE's in Sussex or Kent County and Highmark seems to have doctors in large practices versus a single doctor. To help with engagement, suggest every employee receive an hour of training in these areas.

Motions

Mr. Taschner entertained a motion to approve the Disability Rule and Regulation proposed changes. Ms. Magarik seconded the motion. Motion carried.

Other Business

None

Director Jackson announced the next meeting is scheduled for Monday, September 25th and then requested a motion to adjourn the meeting. Secretary Johnson made the motion and Treasurer Simpler seconded the motion. Meeting adjourned at 4:38 pm.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office